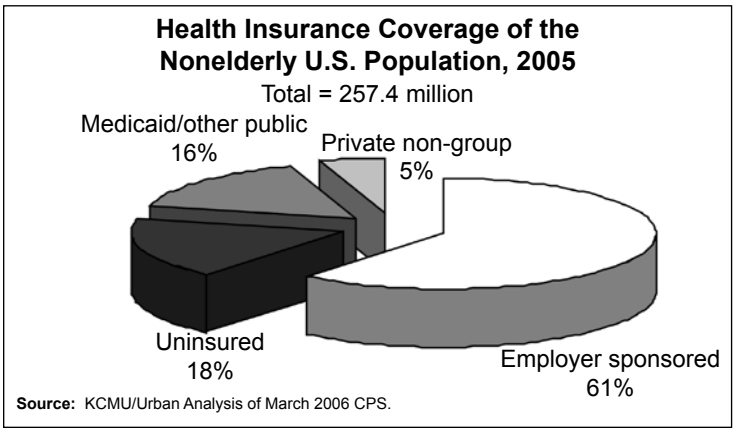
Universal Health Care

By Laura Tobler

Approximately 46 million Americans have no health insurance.

With bipartisan support, many states are creating comprehensive laws or proposals to improve the system and decrease the number of uninsured. They are fueled by the growing number of uninsured Americans, the declining number of employers that offer insurance to their employees, and improved state fiscal conditions.



Several themes are common to state efforts to increase health care access.

Massachusetts and Vermont passed laws in 2006 to achieve universal (or nearly universal) coverage and to address cost and quality. The new Massachusetts program requires people to have health insurance by July 2007. Vermont's law, which includes access to subsidized or lower cost insurance, relies on voluntary participation. Covering all uninsured kids was the initial goal of the Illinois All Kids program that began July 1, 2006, but the state now plans to cover all the uninsured this year or next. Several themes are common to state efforts to increase health care access.

State Action

Individual Mandate. This reform requires everyone to have a minimum level of coverage with some exceptions. Those who do not may be subject to a fine. This strategy is included in the new Massachusetts law and proposals in California, Pennsylvania and Oregon.

Employers provide health care for 61 percent of nonelderly Americans.

Employer Assessments/Mandates. Sixty-one percent of nonelderly Americans have health insurance coverage through their employer. Massachusetts and Vermont assess employers $295 and $395, respectively, per uninsured employee. This money offsets the cost of the new programs. Based on a waiver of the Employee Retirement Income Security Act (ERISA), Hawaii is the only state that can implement an employer health insurance mandate.

In 2006, the Maryland Fair Share Health Care Fund Act was overturned by the U.S. Court of Appeals for the Fourth Circuit. It require large employers to offer a certain level of health benefits to employees or contribute a percentage of their payroll to a public fund, California and Pennsylvania proposals include employer assessments.

ERISA and State Health Policy

Congress passed the Employee Retirement Income Security Act in 1974 to reform and streamline employee benefit packages. The intent of ERISA was to create uniform federal standards by eliminating competing state laws and protecting employee benefits from fraud and mismanagement. The law addresses pension plans in detail but only touches on other employee benefits such as health care. In fact, ERISA's "preemption clause" has been a problem since its inception for state lawmakers who wish to reform health care.

The preemption clause states that "…[ERISA] shall supersede any and all State laws insofar as they relate to any employee benefit plan." These benefits include health care. Thus, state reforms often conflict with ERISA because they relate, directly or indirectly, to employee benefits. States cannot mandate that employers pay for health insurance, directly tax benefit plans, or require reports on cost or use of the plans from employers.

No states provide universal coverage, but four have laws to achieve it.

Medicaid/SCHIP Expansions. Many states expanded Medicaid eligibility to cover more uninsured. Because Medicaid and the State Children's Health Insurance Program are funded with combined state and federal funds, the federal government thus helps fund coverage for the newly insured. Eligibility for children in Hawaii, Vermont and Massachusetts, for example, is 300 percent of the federal poverty guideline ($51,510 per year for a family of three), well above the 133 percent federal requirement. Parents in Arizona, Minnesota and Maine with income at or above 200 percent of the federal poverty guidelines are eligible. Many recent state proposals expand Medicaid and the State Children's Health Insurance Program, and also enhance outreach and enrollment for those who are eligible but remain uninsured.

More states are providing coverage for uninsured children.

Covering Kids Targeting uninsured children is a clear trend. Illinois led the way in 2006 with its AllKids program, which provides comprehensive health insurance to all uninsured children up to age 18, regardless of income or citizenship. Premiums are based on a sliding income scale, starting at $40 per month per child. Bills and proposals under consideration in California, Florida, Kansas, Minnesota, Oregon, Pennsylvania and Washington would provide coverage for more children.

Subsidized Insurance. Many uninsured are low-income adults (about two-thirds have incomes below 200 percent of poverty) in working families for whom coverage is either unavailable or unaffordable. Many existing state programs offer sliding scale subsidies to individuals or small employers to offset the cost of premiums. Massachusetts and Vermont subsidize health insurance on a sliding scale for those below 300 percent of poverty.

Connector or Exchange Authority. Massachusetts in 2006 created a "connector," an independent public authority that pools insurance to offer more affordable, private options to individuals. Subsidies for low-income people to purchase health insurance are offered through the connector. At least seven states included this model in reform proposals.

Focusing on quality, prevention and wellness may help states reduce long-term costs.

Focusing on Quality. Many states included quality initiatives in their reform laws or proposals to improve efficiency and effectiveness and to reduce long-term health care costs. Maine, for example, created the Maine Quality Forum in 2003 with its Dirigo Health Care Act. Vermont is improving chronic disease management. Pennsylvania's reform proposal includes improving patient safety and treatment for chronic conditions such as heart and lung disease, diabetes and asthma.

Prevention and Wellness Initiatives. To better manage health costs and promote healthier living, many states are making health promotion, disease prevention and wellness a priority. The California governor's proposal, for example, would provide incentives to encourage and reward healthy behavior through innovative health benefit designs and also focuses on preventing and treating new cases of diabetes and obesity. Indiana and Rhode Island focused on prevention and wellness.

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